

No. 2  
11-10-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23901

HEB AUG 25 1940

State File No.

1003

6346

Registration District No. 791

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis,  
(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1454a St. Louis Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Thomas J. Kennedy. 530

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 27th, 1875  
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Collinsville, Ills  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Clerk

11. Industry or business \_\_\_\_\_

12. Name Thomas Kennedy

13. Birthplace Canada

14. Maiden name Mary Rowbottom (State or foreign country)

15. Birthplace England  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Nichols,

(b) Address Collinsville, Illinois.

17. (a) Burial (b) Date thereof 7-30-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cem.

18. (a) Signature of funeral director Wm. Reibauer M.D. Co.

(b) Address 2223 St. Louis Ave.,

19. (a) JUL 29 1940 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 26  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1454a St. Louis Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27  
year 1940 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from 1920 19 \_\_\_\_\_ to July 27, 1940  
that I last saw him alive on July 26, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis (chronic) Duration 29y.

Due to Cerebro Spinal 10yrt.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
29y.  
10yrt.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. H. Peeler (M. D. or other) \_\_\_\_\_

Address 2505 No. T. Harrison Date signed 7/29/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed John P. Bushatz

Licensed Embalmer No. 16704

P. O. Address 2225 S. ...

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**